Perspective

A medical meltdown is looming in the Bay State

by Alan Sager,
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This day, all of us together will spend $66 million on health care in Massachusetts. This year, some $24 billion; next year, perhaps $26 billion.

Last May, George Lundberg, editor of the Journal of the American Medical Association, predicted meltdown for U.S. health care by 1996. We are convinced that Massachusetts will be the first to suffer medical meltdown.

Imagine an insolvent Blue Cross, the bankruptcy of many needed hospitals, family health insurance premiums of $15,000 yearly for those who retain coverage, 1 or 2 million uninsured Massachusetts citizens, a growing shortage of family doctors and soaring drug prices.

Enough is already spent in Massachusetts to provide health care that works to the people who need it, so we can avert meltdown if we choose to act. Since national reforms will not be tailored to Massachusetts' high costs, state action is vital to saving our health services.

Massachusetts medical costs per person are highest in the country, and therefore in the world. The United States spends twice what the other industrial democracies do, and health care spending in this state is already one-quarter above the U.S. average. Spending here will rise by about $2.5 billion this year alone. Think of this as a hidden tax increase.

Our analyses show that if present trends continue, state workers' family health insurance costs, now one-fifth of median salary, will exceed one-third of median salary in seven years and one-half in 12.

Despite high spending here, more than 650,000 Massachusetts citizens lack even basic coverage. In 1989, only four states surpassed the commonwealth in the share of population with insurance; by 1991, one-third of the states did so. Insurance premiums are not linked to income, so as they soar, many low-wage workers and employers must drop coverage.

What drives our state's health costs toward meltdown? First, medical care enjoys unusual power and prestige in Massachusetts. Instead of demanding that hospitals contain costs, businesspeople welcome medical care's fifth columnists into their own organizations. For example, half the members of the Massachusetts Business Roundtable's health committee are hospital or insurance executives. One Boston TV station runs an annual telethon for a hospital whose reserves exceed a half-billion dollars.

Second, we allow Massachusetts hospitals to train physicians (residents) at more than double the national rate—and these physicians include many unneeded and unaffordable specialists. Massachusetts citizens pay most of the training bill.

Third, we support an overconcentration of unaffordable and mindlessly competing teaching hospitals and their overpaid executives.

Fourth, with fewer patients per doctor than any other state, Massachusetts physicians may respond by treating patients more aggressively, which can undermine quality while increasing costs.

Fifth, the share of our doctors in primary care is the nation's lowest. The surfeit of specialists means more pressure for costly and duplicative capital projects and the proliferation of esoteric programs.

Sixth, Blue Shield has held down doctors' fees, inducing some physicians to increase volume and intensity of care.

An extraordinarily elaborate and expensive pattern of care has resulted from all this. Though administrative waste here is probably near the national average, clinical waste is probably the greatest of any state. So we would save $4 billion this year alone if our health spending fell to the more-than-generous national level.

Several myths undermine effective action to contain health costs, guarantee coverage for all and protect all needed caregivers.

Myth one: Individual businesses can contain their own health costs. Reality: Businesses hope in vain that costs will be contained by their private regulations and enforced by private bureaucracies of benefits managers, consultants and utilization reviewers. But the rising tide of medical costs continues to lift premiums each year.

Myth two: Because most people are insured through the job, and most uninsured people are in working families, the shortest path to universal coverage is by rounding out insurance protection. Reality: Health insurance fails to protect people or contain cost. Insurers try to manage risk by denying coverage to many of the people who need it most. And after insurers promise unrestricted coverage to some, they try to retrofit such cost controls as utilization review, gatekeepers and higher out-of-pocket payments by patients. But care givers can bypass these restrictions, bringing more waste, frustration and mistrust among all parties.

Myth three: Free-market competition has triumphed over communism, so it can beat the medical cost and coverage problems too. Reality: Worldwide, only direct public and private action to cap health spending has ever contained cost or protected coverage.

Massachusetts has sought to employ more competition. Competitive incentives instituted in 1988 appear to have contributed to marked increases in inpatient and outpatient volume, especially in costlier hospitals. Yet Gov. William Weld and the Legislature completely deregulated hospital payments in 1991, when states that had tried competition were already turning away from it.

Uncapping prices and revenue jeopardizes access and fuels spending. Hospitals do not compete by price, but by promises of quality and service. Vying for prestige and patients, Boston hospitals have recently won state approval for $1 billion in new construction—despite having physical plants already newer than the national average.

Hospitals in competitive markets will cut prices to big buyers for a few years but will shift costs to patients who lack market power. Some hospitals will close as a result, but not usually the less efficient ones. Occupancy rates at the survivors will rise, enabling them to boost prices again. And competition is not likely to save Blue Cross. Its patients are older and sicker because other insurers avoid drives more of its healthier patients toward competitors.

Myth four: Excess hospitals and beds are the source of our high costs, so closing them will save money. Reality: Overcapacity doesn't explain any of our excess costs since our bed-to-population ratio is actually below the national average.

Myth five: Research, training and other legitimate factors justify our state's extraordinary costs. Reality: Legitimate factors account for only one-third of our higher costs. But our high surgery and hospital staffing rates and other evidence suggest an elaborate and intensive style of medical practice. John Wennberg of Dartmouth found Boston's hospital costs to be double New Haven's even though the quality of care seemed identical.

Myth six: Health care spending is creating jobs, so it is good for the economy. Reality: Medical costs weaken the state's economy and retard recovery. An executive at one of Massachusetts' leading corporations told us, "Hospital care may be the number one industry in the state, but it is sucking the economic life out of numbers two, three, four and so on."

Fewer people working outside health care cannot afford to pay for more people working in health care. And our style of medical care is too costly for us and too costly to sell to people from other states or nations. Our hospitals net only about 4 percent of their admissions from out of state, mostly from neighboring states.

Myth seven: Government cannot fix health care problems. Reality: Only government can fix health problems. In all other industrial democracies, the society, through government, makes a few tough, key decisions that set spending ceilings. Government and other payers then negotiate with hospitals and doctors about how to allot funds and cover all citizens. This can be done through either a single government payer or a coalition of government and job-based payers.

Consider the example of drug costs. Other nations negotiate or set prices that people can afford while letting drug companies earn fair returns. But in the United States, unrestricted monopolies on new drugs condemn Americans to pay an average of one-third more than Canadians do.

As a package, these seven myths foster feeble reforms but no real progress. No wonder citizens become cynical.

Nationally, HMOs, utilization review, managed care and the like have all failed in health care. Real health costs per capita rose about 3.8 percent annually in the first half of the 1970s, when these techniques were little used, but 5.4 percent annually in the second half of the 1980s, when they were widely used. Massachusetts remains first in health costs despite having the second highest share of people enrolled in HMOs.

Face reality. Medical costs must grow no faster than the economy, but nothing done recently or now contemplated seriously has a chance of controlling them.

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